

GHC 2009 BLOG ARCHIVE

30 JUNE, 2010 | CREATED USING FIVEFILTERS.ORG

AMSA Global Health Conference 2009 Blog from TIME-sponsored delegates

Below are the captivating posts by your 3 TIME sponsored delegates to AMSA's Global Health Conference for 2009 (GHC 09). Re-live the inspirational moments, or (if you were unlucky/lazy enough to have missed out on tickets) hear a bit about what you missed!

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Day 1 Resource Allocation Workshop Dr. Dan Murphy (American physician from Iowa)

Jul 10, 2009 11:43AM

Day 1 Resource Allocation Workshop Dr. Dan Murphy (American physician from Iowa)

To begin the workshop, the class was split into four groups. Each group was given a scenario that Dr. Murphy himself had personally been involved with. Each group was to work out how the resources available to them could be used to improve their situation most effectively.

My groups situation:

You are a doctor, just got off a plane in Indonesian occupied East Timor during the genocide of the 1990's. You have only your visa and stethoscope in hand and you want to help. What do you do and how do you go about helping? (you also speak Portuguese)

We devised a list:

- Find a secure place to work.
- Contact the locals to spread the word that you are there and want to help.
- Begin helping patients slowly to integrate and build rapport/trust.
- Find back door clinics.
- Use personal and new contacts to gather supplies.
- Determine how best to use these supplies.
- Find transport.
- Avoid confrontation.
- Very dangerous place, do not risk yourself. If something should happen to you, your services are then useless and people will die.
- Use the media to draw international attention to the situation and call for help/supplies.
- Use personal contacts to help spread the word internationally, use them to speak on your behalf.

Other situations:

You work in a large hospital in California and several hundred illegal aliens from Mexico come into the ER. They have been working for a local farmer and were holding a strike for better pay. The farmer in retaliation sprayed them with organo phosphates (a dangerous toxin). They are uninsured and likely to be deported should you treat them. How do you go about this situation?

You are working in East Timor and you see several heart cases a day that could easily be treated with simple surgery but you do not have the facilities to do so. You know of a large cardiac clinic in Australia that could easily add cases to their workload and saves several lives. The doctors and staff of the clinic want to help you as long as you can secure funding and a way to get these patients to them. How do you go about getting expensive replacement valves for the surgery and allow the Australian government to grant these patients access to the country for treatment?

Jon Marino said:

Global Health Conference Day 1 'International Day'
02/07/2009 Thursday

Dr. Sujit Kumar Brahmochary 'Show What We Can Do'

Dr. Sujit is currently the director of the Institute for Indian Mother and Child. He did not title his talk but the recurring theme was of 'showing what we can do.' His life work has been overwhelmingly motivational and emotional. His lecture was humorous, intriguing, and gripping and has my vote as the best of the conference.

Dr. Sujit began his lecture with a little personal background. He obtained his medical degree in Calcutta and specialized in paediatrics in Belgium. But, his story really begins at the end of his time in Belgium, which is when he came to the realization that his services as a physician would be put to far greater use in back India.

He returned to India and with the help of some mentors worked his way to the position of medical director in the Mother Teresa Hospital, a position that he held in for two years. In this role he worked in direct contact with Mother Teresa herself. After two years of serving as medical director he decided to venture out on his own and help others who were in dire need. He spoke to Mother Teresa about his ideas and she told him that she would not implant him into an area with a pre-established medical facility (by pre-established I mean, a medical facility that was in the making or being developed) and that she would not give him money or supplies to begin his journey. She said to him, and I am quoting his words, "go build your own and understand what it means to changes life yourself." Resonating words from such a figure.

Dr. Sujit followed Mother Teresa's advice and moved to an extremely underprivileged area with no medical services

and decided to set up shop. After months of begging, a farmer finally allowed Dr. Sujit to hold clinic once a week in one of his cow sheds. Everything grew from there. From that day his work as resulted in 27 facilities including hospitals with full features of operating rooms and government funding. His work as also lead to the development of several schools. There is much more to this side of his story, please ask questions if you have any.

Some of his key points that I found to be enlightening or of specific importance are the following:

Dr. Sujit referenced Mahatma Gandhi relatively frequently. Gandhi said that humanity would be best served by the two H's, thinking with the Head and Heart. Dr. Sujit added a third H, Hands. Meaning that to serve humanity and create change or make a difference we, as physicians, have to get involved and get people to believe in us. We have to think with our heads and hearts but do with our hands, create a plan, have ambition, and get into it.

Dr. Sujit was asked about how he secured funding when he started his humanitarian work. Certainly a thought we all have as medical students... How are we going to pay for all of this???

His advice was to begin your work treating small cases. Build rapport with the community, develop trust, show compassion, be creative (i.e. he showed a picture of how he warmed a premature baby with a light and cardboard box, saving its life), and most importantly do good things. His overall response to the question was that if you do good things and treat everyone that you can, even if that means sacrificing some of your own personal wealth, people will discover your work and the money that the community needs will follow. There is no need to go looking/searching for it just as long as you throw yourself into your work as best you can, the funding is there but people need reassurance that it can be used properly and that you are the person who can use it in that way. But critically, you have to see the good in everything you have and view life as a glass that is half full.

I got a chance to speak with Dr. Sujit and his wife at lunch and found him to be incredibly insightful and if you would like to know more about him and his story (and trust me there is much much more to tell) please contact me or ask a question on this thread.

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Day 1 Disaster Relief 'A Surgeons Experience' Dr. Peter Sherwood

Jul 10, 2009 10:52AM

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Dr. Sherwood runs a private orthopaedic surgery practice here in Brisbane but his primary role in his career as a physician has been with the Australian military. He has served worldwide in military hot zones and in times of peace as a relief aid worker.

He began his talk by time lining the role that war has played in the teaching of new surgeons and developments of new medical techniques/surgeries. I was surprised to learn of how many great physicians and pioneers of medicine have been trained on the field of battle where 'necessity is the mother of all invention.'

He finished his talk by describing some of his own experiences as a physician/surgeon on the battlefield. He showed many detailed photographs (of mine victims to gunshot victims to the malnourished) and was able to recall exactly what caused the wounds and how he managed to correct them. His overriding tone was one of stress. There was always something to worry about if not just your patients, worry about being bombed, captured, or even helping refugees. He described many times in which he was not allowed to treat the wounded/sick who were several meters away due to political lines. His story was motivational and informative.

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Saturday 4th July Though the...

Jul 8, 2009 07:15AM

Saturday 4th July

Though the big excitement for the was supposed to be the 'Challenge Day' events, the most moving moment of the conference actually came from a film screened during the day.



The film was entitled **Triage: Dr. James Orbinski's Humanitarian Dilemma**, and follows the former international president of MSF (Medecins Sans Frontieres, aka Doctors Without Borders). In this documentary, he relives his experiences providing aid in Somalia, Rwanda and Congo. His experiences have clearly had a profound effect on him, and scarred many of those he shared those experiences with — and the many he has saved the lives of. It is difficult to describe the impact of the film — so I suggest you get your hands on a copy of the DVD and watch it for yourself, it is well worth watching more than once! Perhaps it is enough to say that stifled sobs and silent tears were shed by the audience as images of children too weak to lift food to their mouths, children crawling and collapsing from famine

cast silence on the lecture theatre. I felt truly motivated after this film.



Above: 1.4 billion people, today, still live in extreme poverty. For comparison, the total population of Australia is just under 22 million. Extreme poverty = the most severe state of poverty where many cannot meet the basic needs for food, water, shelter, sanitation and health care.

Simon Moss (founder, Global Poverty Project): Health is the very best thing we can do to help lift people out of poverty. When we get health right, the whole community does better. We learnt of the numerous barriers to addressing extreme poverty, and (of course) the need to deal with these. **Barriers to addressing extreme poverty:**

- Them vs. us attitude, political will, corruption, rights/politics, infrastructure, harsh environments/difficult terrain, family planning, discrimination

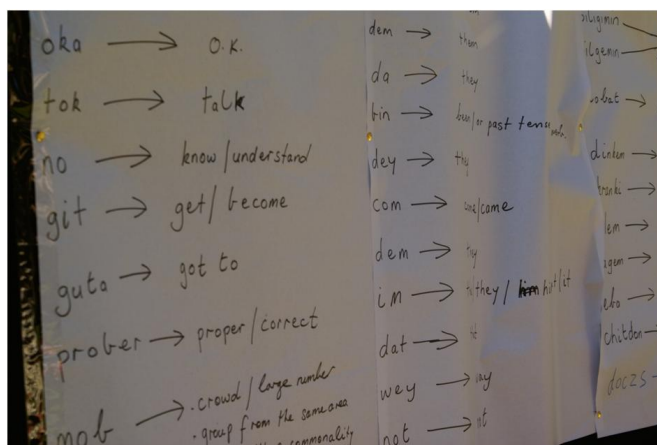
Photos from Challenge Day events:



Challenge day involved a series of 10 stations which required teamwork and shared expertise in solving scenario based problems. Above, a team discusses the logistics of providing sanitation, water and food to a poor community. The team is given limited resources, restrictions (e.g. the maximum distance between living quarters and a water source was 1km) and a mindset for sustainable difference.



Above: delegates deliver a baby in a 'foreign country' (language barrier!), where the husband of the mother is nearby after involvement in a motorcycle crash with a quickly spreading fire. The husband was initially unconscious, sustained spinal injuries, spoke no English and was threatened by fire spreading towards him from the fuel leaked by the motorcycle.



Above: This station involved the translation of a true account of the arrest of an indigenous youth. It highlighted the way in which cultural differences often lead to misunderstanding and poor outcomes.



Above: in this scenario half the team took on the role of Red Cross Delegates attempting to enter and inspect a facility detaining prisoners of war. The other half of the team took on the role of prison guards (two of whom needed medical treatment

for TB).

Sunday 5th July – the final day

Dr Nick Coatsworth - Vice-President, MSF Australia)

Perhaps suprisingly, Dr Coatsworth, brought out two important considerations in humanitarian work that only came out at the end of the week:

1. Dr Coatsworth shared with us a personal experience when the team he was working with withdrew from an area in the Congo. Overnight, the medical facilities and staff effectively dropped to one doctor. Dr Coatsworth had befriended a local staff member who was paid out when the team left. This team member was subsequently killed by militia for his money.
 - We must be careful of the unintended consequences of aid work — especially with respect to what may happen when the aid agency withdraws. Are there handover plans? Are they sufficient?
2. The recent trend towards humanitarianisation of military intervention has been a problem. Of particular note, the US military has consistently deployed in the name of humanitarian efforts — this has lead to aid organisations being associated with military objectives. The MSF have subsequently been refused entry or booted out of many places because of this. We must be careful to maintain a public image of aid agencies that is conducive to their work.

A summary of what GHC was to me:

Inspiration — from hearing first-hand the many things achieved by those who got stuck in and did the work

Motivation — from hearing about all that is yet to be achieved

Empowerment — from hearing how things have been achieved, and how things can be achieved

Thanks GHC '09. Bring on Tassie GHC '10!



Arthur Cheung
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Friday 3rd July Tania Major...

Jul 8, 2009 05:50AM

Friday 3rd July



Tania Major - indigenous health advocate

In summary: indigenous health is *our* problem, and we need to commit to solving this as a nation. This commitment must be genuine — we need to work *with* the community, rather than work *on* it from 'above'. Understanding is key — and this must come through immersion in the environment and proper consultation. This message was echoed in the mantra expounded by the AMSA indigenous health liaison: "treat patients as people, not cases"

- **Tania on bureaucracy:** "fuck it ... just get out there and do it"
- **Tania on grassroots action:** "it's the way to go"
- **Tania on being congratulated for 'what you have done for your people':** "it's *our* people, not *your* people ... we are *all* Australians"



Murray Proctor - Deputy Director General of AusAID, HIV/AIDS ambassador

- **on healthcare priorities:** We put too much into topical/politically interesting diseases, while the real importance is funding primary health care in these countries — in a stable manner from year to year.
- **on combating HIV/AIDS:** basic education of women and girls is the most important thing for HIV/AIDS — knowledge of safe hygiene practices, literacy so they may be able to read healthcare instructions (e.g. how to take meds)

We are more than **halfway to the year 2015** (target date for achievement of the Millennium Development Goals), and here is the status of the 3 UNMDG goals relevant to HIV/AIDS:

- No.4 — reduce child mortality by 2/3s
 - only 29% reduction so far
 - currently more than 190,000 children under 5 years old die of diseases *each week*
- No. 5 — reduce maternal mortality ratio by 3/4s
 - only 6% of the way there so far
 - currently, 10,000 women die *each week* from treatable complications of pregnancy and birth
- No. 6 — half and begin to reverse the spread of HIV/AIDS (and also other major diseases, including malaria)
 - number of newly infected each year is falling, but 2.5 million are still newly infected each year
 - currently, we have 33 million people infected with HIV, and more than 2 million die each year from AIDS



Philip Sutton — Climate Change

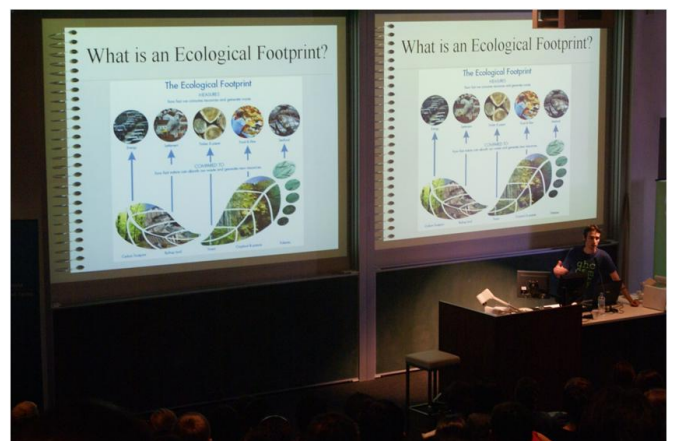
The run down: a big problem, widely recognised, but also widely ignored. The situation is akin to cardiac arrest — potentially reversible, but we must rapidly take emergency intervention.

Points to note:

- Towns previously built above the altitude which mosquitoes (and thus malaria) reach are now malarious — rising global temperatures allow mosquitoes to venture higher.
- Climate change is a viscous cycle — e.g. increase in temperature -> melting of ice -> loss of reflective properties -> increase in temperature

Points to ponder:

- If we get a fever of 40 degrees, we expect treatment to take it down to 37 degrees, not 37 + an increment for damage. Why do we treat aims for global warming differently?
- In medicine, preventative intervention is better than curative. Why do we treat global warming differently?
- At the UN Climate Change Conference in Copenhagen later this year, they will be debating to what extent they will implement a plan that may confer (at best) a 50/50 chance of preventing a 2 degree increase — an increase which is not compatible with sustainable life on Earth!
- We may have reached the stage where Earth requires emergency treatment — stabilise before definitive treatment. E.g. reflective roofs on urban dwellings.
- In WWII, 40c of every dollar in the US economy was turned to war. Climate change is a bigger threat than WWII was. How much of each dollar is currently spent addressing this threat?
- Society can't drift into an emergency mode of action, but we can drift into an emergency. The decision to address climate change must be a conscious decision — it won't 'just happen'.
- The generation before us has failed to address climate change. It is now the responsibility of our generation — temporary hardship is the price we will need to pay to prevent long-term extreme hardship/death due to e.g. widespread famine.





Above: Global warming is a health problem. In response to this, a new initiative was introduced at GHC 09 — offering conference delegates the opportunity to carbon-offset their participation in the event. If each delegate forked out \$25, our carbon footprint would have been neutral. Alas, 'technical difficulties' (i.e. difficulty finding Sean to pay him!) meant we missed our target of 1/4 people participating. 10% of delegates participated in this voluntary scheme. Still, a step in the right direction.
